STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 17,932
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the decision by the Department of Aging and Disabilities substantiating a report of abuse by the petitioner of elderly and disabled individuals who were residents in the nursing home where the petitioner worked.

FINDINGS OF FACT

1. The petitioner has worked several years as an aide at the Veterans Home in Bennington, Vermont. Until about a year ago, she worked in a wing of that facility that houses dementia and Alzheimer patients.

2. When she worked on the Alzheimer wing the petitioner had received some complaints from staff and oral reprimands from supervisors regarding her "gruff" demeanor and "rough" handling of patients. On one occasion a social worker who was observing employees immediately after a training observed what-she-felt-to-be the petitioner's "rough" handling of a patient while she was putting him to bed.

3. The petitioner's immediate supervisor, an L.P.N. who worked with the petitioner on the Alzheimer wing for a year and a half, testified that she spoke to the petitioner on an unspecified number of occasions when she observed the petitioner waking residents up too abruptly by yanking down their blankets when it was time to change them. The supervisor also stated that on one occasion she observed the petitioner hurt a resident by washing him too roughly during a catheterization procedure.

4. None of the above incidents led the petitioner's employer to take any specific action against her or to report any incident to the Department.

5. About a year ago, a coworker who worked as an aide with the petitioner reported to her supervisor that the petitioner had become angry with a patient while assisting him with dressing and had unnecessarily and forcibly pushed him back onto his bed, telling the coworker to make him dress himself. The coworker testified that she thought the resident was "scared" by the petitioner's action.

6. The coworker also testified that prior to the above incident she had on occasion observed the petitioner to be verbally threatening and disrespectful to patients, although she had not reported these incidents at the time.

7. While not specifically denying any of the above incidents, the petitioner essentially testified that they were misinterpreted, exaggerated, or taken out of context by the witnesses who described them. As for the pushing incident, the petitioner maintains she just "touched" the patient on his shoulder and that he fell back on the bed. However, the testimony of each of the Department's witnesses in describing all the incidents in question was deemed to be credible.[1]

8. Following the coworker's report of the pushing incident, the Veterans Home reported the incident to the Department. After an investigation, the Department concluded that all the above incidents constituted a "pattern of treatment" of patients by the petitioner amounting to a "reckless disregard" for their health and welfare.

9. After the pushing incident was reported by the coworker, the Veterans Home transferred the petitioner to another wing, where she has worked (apparently without

[1] Following the Department's presentation of evidence (on October 7, 2002) the matter was continued to allow the petitioner to call witnesses she said would verify her version of the events in question. On the day scheduled for that purpose (November 4, 2002) no witnesses appeared for the petitioner.

incident) for the last year pending the outcome of this appeal.[2]

ORDER

The Department's decision is affirmed.

REASONS

The Commissioner of the Department of Aging and Disabilities is required by statute to investigate reports regarding the abuse of elderly persons and to keep those reports which are substantiated in a registry under the name of the person who committed the abuse. 33 V.S.A. § 6906, 6911(b). Persons who are found to have committed abuse may apply to the Human Services Board pursuant to 33 V.S.A. § 6906(d) for relief on the grounds that the report in question is "unsubstantiated".

The statute that protects elderly adults, 33 V.S.A. § 6902, includes the following definitions of "abuse":

As used in this chapter:

(1)"Abuse" means:

[2] It was not explained at the hearing why the case had taken so long to get to the Board (the petitioner's request for appeal having been received by the Board on August 9, 2002).

> (A) Any treatment of an elderly or disabled adult which places life, health or welfare in jeopardy or which is likely to result in impairment of health;
>
> (B) Any conduct committed with an intent or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain or unnecessary suffering to an elderly or disabled adult;
>
> . . .
>
> (E) Any pattern of malicious behavior which results in impaired emotional well-being of an elderly or disabled adult.

As found above, credible evidence in this case establishes that the petitioner, while engaged in her work as an aide at a nursing home, had on several occasions been obser8ved, and in some cases reprimanded for, treating patients in her charge in an inappropriate manner. The evidence is also clear, however, that none of these incidents, which involved inappropriate verbal comments to and "rough" handling of patients, led her supervisors or coworkers to take any action against the petitioner or to make any report to the Department. Thus, the petitioner could well argue that these incidents, either singly or in combination, were not serious enough to meet any of the above definitions of "abuse".

However, credible evidence also establishes that the petitioner's conduct culminated in an incident in which she became angry with a resident and forcibly and unnecessarily

pushed him onto his bed--an event which led to the instant investigation. Again, the case would be problematic if this were the only proven incident of inappropriate conduct by the petitioner. However, in light of the prior incidents, it is difficult to view the latter incident of forcibly pushing a patient onto his bed as an isolated or unusual manifestation of the petitioner's overall behavior and demeanor toward the patients in her care. It is the petitioner's history of inappropriate treatment of residents that supports the conclusion that the pushing incident was "reckless" in its disregard of the likelihood it could cause unnecessary suffering to that patient within the meaning of the above statute. Thus, the Department's decision in this matter is affirmed. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 17.

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